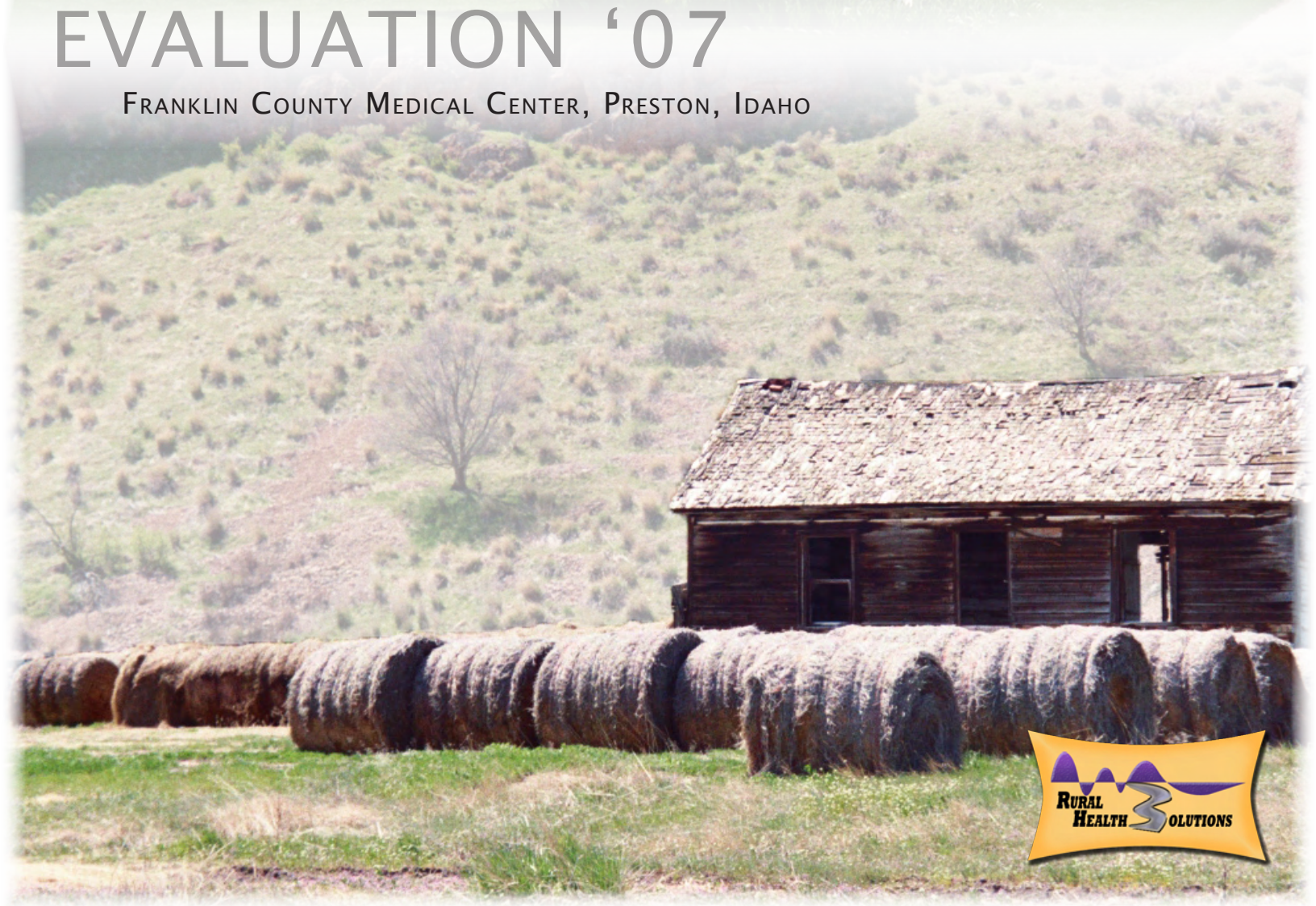
A Critical Access Hospital
Case Study

Idaho Flex Program

EVALUATION '07

Franklin County Medical Center, Preston, Idaho



IDAHO FLEX PROGRAM

Franklin County Medical Center
Preston, Idaho EVALUATION '07

Is the Medicare Rural Hospital Flexibility (Flex) Program and small rural hospitals' conversion to Critical Access Hospital (CAH) status improving the quality of care and the performance of small rural hospitals, enhancing local emergency medical services, and fostering network development? A case study highlighting Franklin County Medical Center, Preston, Idaho, was conducted as part of Idaho's Flex Program and its program evaluation activities to examine these questions.

CASE STUDY OBJECTIVES AND METHODS

The Franklin County Medical Center case study was conducted to identify community, hospital, and other health care related changes and outcomes that have occurred due to Franklin County Medical Center's conversion to Critical Access Hospital (CAH) status and its involvement in the Flex Program, as well as to identify needs and issues for program planning purposes. Case study activities included the following:

- Local health services and community background information was collected from February – June 2007 on Preston, Idaho, and Franklin County, Idaho.
- Interviews of hospital staff, hospital board members, and local emergency medical services (EMS) personnel were conducted in Preston, Idaho, in April 2007.
- A survey of health care providers (physicians and certified registered nurse anesthetists) working in Franklin County Medical Center was conducted in February 2007. The survey resulted in a 71 percent response rate.
- A community focus group was conducted in Preston, Idaho, in April 2007.

71% response rate

Twenty-three individuals from the hospital service area were included in the case study process. They were asked questions related to: the hospitals' conversion to CAH status, changes that have occurred at the hospital over the past 10 years, quality of care, networking activities that have occurred, changes to EMS services, and community needs and issues.

The Idaho Department of Health and Welfare, Office of Rural Health and Primary Care, administers the Flex Program in Idaho and is the sponsor of this case study. Rural Health Solutions, St. Paul, Minnesota, conducted the case study and prepared this report.

PRESTON, IDAHO, AND THE SURROUNDING AREA

Preston is located in southeastern Idaho near the Utah border. It is the county seat of Franklin County, named for the first settlement in Idaho. Franklin County has an area of 667 square miles consisting of plains with mountains on the east and west boundaries. Historically an agricultural area, it increasingly has economic ties to seasonal recreation activities such as fishing, hunting, snowmobiling, camping, and hiking. It is also an evolving bedroom community for Logan, Utah, which is located 27 miles south of Preston on a newly developed 4-lane highway. The largest employers in Preston are the Preston School District, Franklin County Medical Center, and Nyoplast America (pipe fittings). Local farmers and ranchers raise wheat, barley, corn, oats, beef cattle, sheep, lamb, and hogs.

preston

population in 2000 = 4,682

population in 2006 = 5,089

In 2006, the estimated population of Preston was 5,089, an 8.7 percent increase in population compared to 2000 (4,682). Preston lies along Highway 91 about 69 miles south of Pocatello, Idaho, and 27 miles north of Logan, Utah, where the nearest tertiary hospital is located. Bear Lake Memorial Hospital, located in Montpelier, Idaho, and also a CAH, is the nearest Idaho hospital to Franklin County Medical Center, located forty-six miles away. When asked, "What makes Preston a healthy place to live?", case study participants characterized the community as having: "fresh" "clean" air, easy access to many outdoor activities, slower paced lifestyle, a local health fair that attracts over 1,000 people annually, people who care about one another, little crime, people who are self-sufficient, many people who grow their own food, and an emphasis on wellness. When asked, "What makes Preston an unhealthy place to live?", case study participants reported: 2-3 weeks of annual air inversions that trap pollution in the valley, high cancer rates, many people who make personal choices to drink and smoke, lack of health insurance, poverty, lack of interpretive services for the growing Hispanic population, lack of physicians, limited to no social settings/opportunities (e.g., movie theatres, shopping malls), and high prescription drug abuse.

FRANKLIN COUNTY MEDICAL CENTER

Franklin County Medical Center, a 20-bed CAH, converted to CAH status August 1, 2003, making it the 21st hospital to convert in Idaho and the 800th to convert in the U.S.[1] The hospital is county-owned and offers emergency care, general surgery, obstetrics, orthopedic surgery, hospice, school health services, and a variety of outpatient services. The hospital also owns a 45-bed attached long-term care facility and a home health service. The hospital administrator has been working in the hospital for over 20 years, the Chief Financial Officer 11 years, the Chief Nursing Officer 29 years, and the Quality Improvement Coordinator 10 years. There are 11 physicians (3 full-time and 8 visiting/consulting), no physician assistants/nurse practitioners, and 141 full-time equivalent (FTE) employees working at the hospital.[2]

Franklin County Medical Center's service area population of approximately 12,300 is characterized as wealthier, younger, less racially diverse, and more likely to have a high school diploma, but significantly less likely to have a college degree when compared to other people in the state.[3] The hospital has experienced an increase in utilization of services over the past 20 years, in particular in the areas of surgery, laboratory and radiology, labor and delivery, and emergency room. The hospital's 2006 annual average census for inpatients was 3.6 per day while swing bed census averaged one per day.

Ambulance services for the area are provided by Franklin County Ambulance. It provides Intermediate Life Support-Advanced services through 52 trained emergency medical technicians (12 EMT-Advanced and 40 EMT-Basic) and 10 First Responders, with little staff turnover. At 450 runs in 2006, the ambulance service has experienced a steady increase in its run volume over the past five years. The increase in run volume is attributed to increases in population, tourism, and participation in a number of local events (e.g., filming of the movie Napolean Dynamite, local motor cross and rodeo events.)[4]

1. As of October 5, 2006 there are 26 CAHs in Idaho and 1284 in the U.S. Source: Flex Program Monitoring Team.
2. One Nurse Practitioner is employed by the hospital but serving as the Director of Home Health Services.
3. Franklin County QuickFacts. [Retrieved June 2007]. *http://quickfacts.census.gov/qfd/states/16/16041.html*
4. As reported by Franklin County Medical Services, April 2007.

impact
OF THE FLEX PROGRAM

"Deciding to convert to CAH status wasn't just a good decision, it was an excellent decision."

— Case Study Participant

The national Medicare Rural Hospital Flexibility Program was created as part of the federal Balanced Budget Act of 1997. Its goals are to: 1) Convert small rural hospitals to CAH status; 2) Support CAHs in maintaining and improving access to rural health care services; 3) Develop rural health networks; 4) Integrate EMS into the continuum of health care services; and 5) Improve the quality of rural health care. Franklin County Medical Center was selected for an impact analysis using a case study approach in order to examine program outcomes and the impact that the Flex Program has had on local communities. Data were obtained from the Idaho Department of Health and Welfare, Office of Rural Health and Primary Care, State EMS Bureau, and the national Flex Monitoring Team, as well as case study participants. Case study participants were asked questions related to each of the Flex Program goals, focusing on outcomes, accomplishments, needs, and on-going issues. Below is a status report for each goal, including: goal status, indicators for success and indicators of on-going needs and issues. Although many of the indicators cannot be directly and/or purely attributed to the activities of the Idaho Flex Program, case study participants reported that without the Flex Program, each accomplishment would have been difficult, delayed, and/or not pursued.

Goal: Convert Hospitals to CAH Status
Status: Accomplished

Indicators of Outcomes Achieved:

- Franklin County Medical Center converted to CAH status August 1, 2003.
- It took the hospital approximately eight months to explore the CAH conversion option, complete a financial feasibility study, work with Flex Program supported staff at the Idaho Hospital Association and the Office of Rural Health and Primary Care to prepare for and complete the CAH application process, and be surveyed and licensed as a CAH.[5]
- The hospital had only one deficiency, which was corrected, during its survey and licensing process.
- All of the health care providers surveyed as part of the case study reported that they are aware their hospital is a CAH and one was involved in the hospital's decision to convert to CAH status.

"We have an objective to not only break even but also to serve the community and their health needs."

— Case Study Participant

5. This does not include the time associated with the initial three financial feasibility studies that were conducted and indicated that conversion to CAH status would have a negative/no/minimal financial impact on the hospital.

Comments/information by case study participants related to the CAH conversion process include:

— *"Our biggest decision was to determine whether CAH conversion was a good financial decision."*

— *"Conversion wasn't a big deal; it was really a paper process."*

— *"Without IHA's [Idaho Hospital Association] help to facilitate some of our needs, such as the peer review process, we wouldn't have known what to do or how to do it."*

— *"CAH credentialing [as part of the Flex Program], this was extremely helpful. We had contracted with an outside service and they were inadequate."*

— *"CAH status has been good as it has improved our cash flow, helped our bottom line, and we're in the black more months."*

— *"The state office of rural health (Idaho Office of Rural Health and Primary Care) provided excellent support and assisted with our policies and procedures."*

Goal: Support CAHs in Maintaining and Improving Access to Health Care Services
Status: Outcomes Achieved/On-going Needs Exist

Indicators of Outcomes Achieved:

- The hospital has not eliminated any services since conversion to CAH status.
- The hospital has added orthopedic coverage, additional anesthesia services and a staff grant writer. It has updated equipment (e.g., lab, EKG), and is increasingly customizing care services to meet community needs.
- The hospital's financial performance has improved slightly. This limited improvement is primarily attributed to the hospital's small percentage of Medicare patients (23 percent).
- The CAH peer review network, sponsored by the Flex Program and implemented by the Idaho Hospital Association, supports the hospital's peer review given the limited number of physicians on staff.
- CareLearning.com, a program initially sponsored by the Flex Program, is used by hospital staff for training (e.g., EMTALA). This has allowed the hospital to offer training on an as needed basis and to reinforce quality standards.
- The hospital has used Flex Program support for attending conferences and workshops
- An electronic health record, Computer Programs and Systems, Inc. (CPSI), is being installed using a phased approach. Radiology, pharmacy, home health care, financial, and management services are on the system.
- Hospital staff report that the Balanced Scorecard, an initiative funded through the Flex Program, has helped the hospital focus on its mission and report activities to the hospital board.
- Hospital staff report the hospital received a $30,000 Flex Grant which will be used to support the implementation of an electronic health record in physician clinics. This work is intended to improve coordination of care between the hospital and clinics and also to enhance physician recruitment.
- Fifty percent of health care providers surveyed as part of the case study report that they are involved in activities to promote health/prevent disease.

"Ten years ago, the perception was that the hospital didn't provide high quality of care; that has changed."

— Case Study Participant

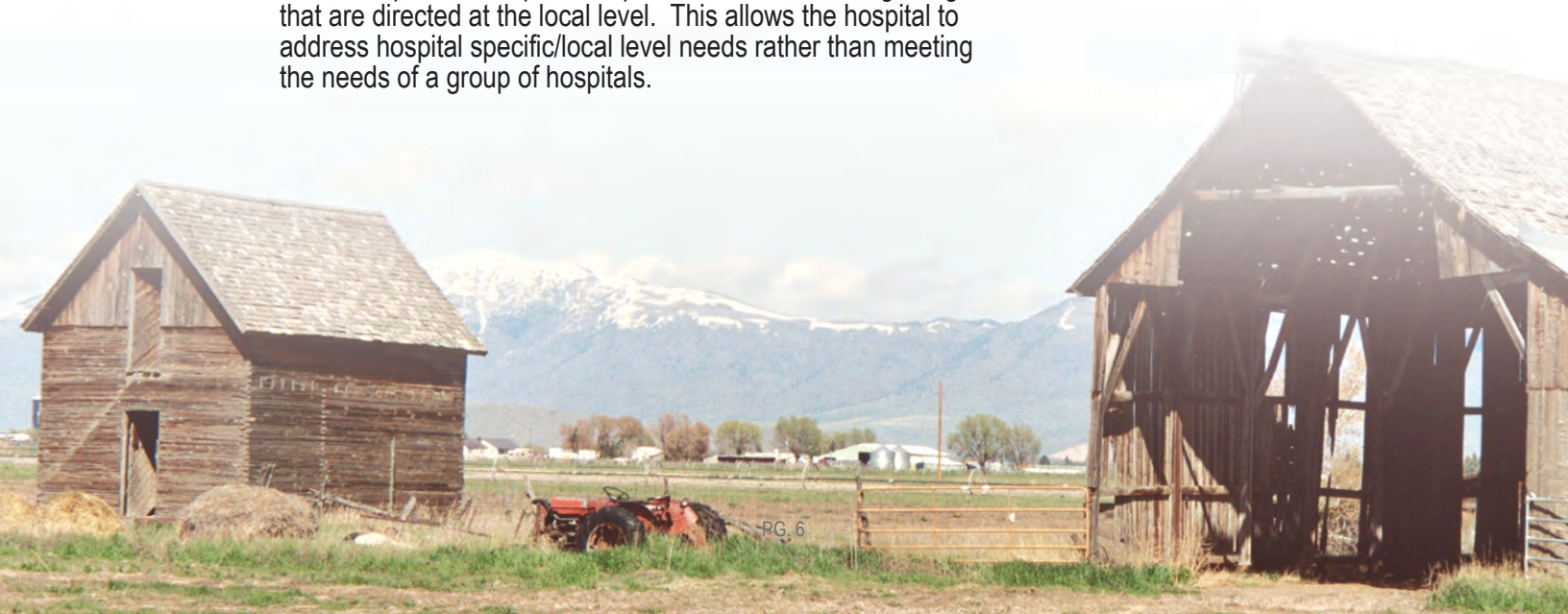
- Comments/information by case study participants related to supporting the CAH and maintaining/sustaining access to health care services include:
  - — *"The Flex Program is the only way we have been able to participate [in conferences]."*
  - — *"The benefits of being a CAH are not just related to reimbursement. We have access to grants, training, and other cooperative activities that we wouldn't have access to."*
  - — *"I arrived at the hospital at 11:00am, got a CT scan and was back in my office at 11:20am. That shows you how easy it is to be a working person here and still make time commitments."*
  - — *"All rural hospitals in Idaho are CAHs which provides us with access to knowledge."*
  - — *"Access to education, training, technical assistance, and grants, these actually mean more to us [the hospital] than the additional reimbursement."*

"If our operating room is busy and we have an emergency C-section, we are in trouble."

— Case Study Participant

Indicators of On-going Needs/Issues:

- Hospital staff report a need for additional hospital information technology staff and staff training.
- Hospital staff report that demand for health services and changes in the provision of health services has resulted in the hospital's physical plant not being adequate.
- Hospital staff report a need to recruit an additional physician.
- Community members report that they are unaware of any physicians in the Preston area that are accepting new patients.
- Twenty case study participants (91 percent) reported that the hospital needs a new physical plant.
- Surveyed health care providers indicate: the need to build a new hospital, the ability to recruit physicians and specialists, and access to affordable health care services are the greatest health care issues facing Franklin County Medical Center's patient population.
- One health care provider surveyed as part of the case study reported that he/she is unaware of the meaning of CAH.
- Some hospital staff reported a preference for Flex Program grants that are directed at the local level. This allows the hospital to address hospital specific/local level needs rather than meeting the needs of a group of hospitals.



- Comments by case study participants related to supporting the CAH and maintaining/sustaining access to health care services needs and issues include:

  — *"If we don't stay competitive, they [patients] will leave us and go to Logan (UT)."*

  — *"The plans are already in place for over 400 lots to build single family and town homes. So it's inevitable, the community is going to continue to grow."*

  — *"We need a new hospital: my office was a closet, we have to take over the labor room for pre-operation work-ups, and it's hard to maintain HIPAA when you have someone right on your elbow everywhere you are."*

  — *"Having access to conferences and workshops allows us to broaden our horizons. Otherwise, we would get stuck in our part of the world."*

  — *"We cannot afford to build a new hospital without taxpayer support."*

  — *"In bigger places there are mechanisms in terms of discipline [staff and physicians]. We can't do a lot of that stuff because we can't afford to lose anyone."*

  — *"Our IT [information technology] staff is one guy and he has been learning as we go. We need support from someone who is knowledgeable in hospital IT."*

  — *"I only know how good our care is because I work here."*

  — *"Our local schools are experiencing an increase in the number of students with special needs."*

  — *"We need to do better at collecting more detailed information when they [patients] arrive at the ER [emergency room] so we can track and bill them."*

  — *"I'm not sure whether the people [community] are aware of the good things we do [at the hospital]."*

Goal: Develop Rural Health Networks
Status: Accomplished

Indicators of Outcomes Achieved:

- The hospital formalized its network relationship with the Portneuf Medical Center, Pocatello, and reports the development of the Flex Program and its required networking arrangement has improved hospital relations and collaboration between the facilities.
- The Flex Program has supported the development and work of the Public Hospital Cooperative which includes 12 hospitals in Southeastern Idaho and one hospital in Wyoming.
- Local EMS is working with a neighboring ambulance service to share ideas on improved operations, staff training, and recruitment.
- Comments/information by case study participants related to network development include:

  — *"Our hospital is owned and operated by the county and we have no system to call upon. Therefore, we rely on our network [Southeast Idaho Public Hospital Cooperative] to get our staff educated and to network with other staff."*

Indicators of On-going Needs/Issues:

- None noted.

Goal: Integrate EMS into the Continuum of Rural Health Care Services
Status: Outcomes Achieved/On-going Needs Exist

Indicators of Outcomes Achieved:

- Activities (such as joint training) are in process to improve EMS-hospital relations.
- Hospital employees have been trained as EMTs and they are active members of the local EMS squad.
- An EMS training system was purchased using Flex Program funding. This included the purchase of hardware, software, and a SMART board. EMS staff report the equipment is used by the whole community for training and over 100 courses have been conducted.
- A local EMS assessment was completed by the Flex Program to identify community EMS needs that should be addressed. The following local activities were completed/are in process in response to assessment recommendations:

  — *A staff satisfaction survey was completed. Survey data indicated that limited involvement by some EMS squad members was due to personality conflicts.*

  — *An EMT training program is in place which allows for internet-based recertification training.*

  — *Plans are in place to complete county-wide long range planning to improve the interoperability of police, EMS, and search and rescue.*

  — *Existing data is being used and expanded to assist with agency planning, staffing, budgets, and system improvements. Data has also allowed the squad to identify training issues and to adjust the training schedule to respond to those issues.*

  — *Ambulance drivers are now required to complete an emergency vehicle operator course prior to operating an ambulance.*

  — *A mapping system is being created for use in laptops that will be located in each of the ambulances. This mapping system will assist with location identification and response times.*

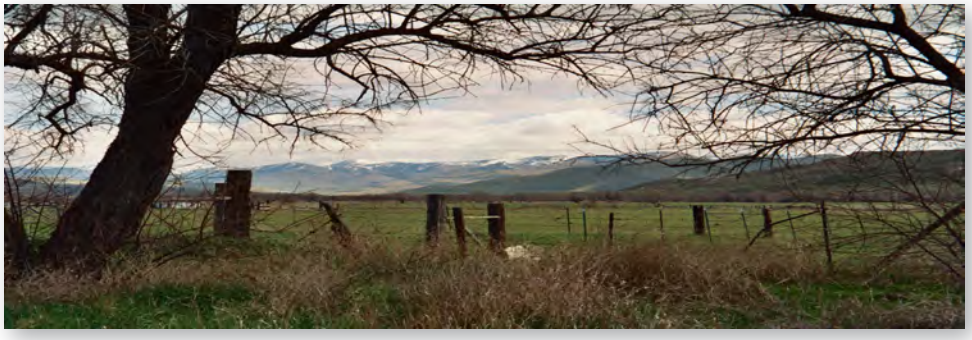
  — *A State developed, standardized, EMS medical director position description was presented to the current EMS medical director.*

  — *Local EMS is working to establish compensation for the medical director.*

  — *The EMS medical director is assisting with protocol review, planning, and development of triage/transfer guidelines.*

"The new fire station and EMS building has helped our staff morale because we have a nice place to meet and train."

— Case Study Participant



Indicators of On-going Needs/Issues:

- The following local activities, suggested in the Flex Program's local EMS assessment recommendations, have not been completed or are not in process:

  — *An EMS volunteer retention/recognition program has been discussed but not pursued.*

  — *Although technical assistance has been sought from the State's EMS Bureau and the regional director, the regional office was closed and/or has been consistently understaffed. Therefore, staff are unavailable and unable to provide technical assistance.*

  — *The new EMS medical director has been approached to discuss support for personnel training, continuing education, and EMS personnel skill verification; however, little progress has been made.*

  — *Although local EMS is interested in pursuing joint training opportunities with the hospital, this has not been attempted/completed.*

  — *Attempts were made to expand the County Ambulance Board to include broader membership; however, the County commissioners decided that Board membership would remain.*

  — *A computerized feedback program between the hospital and local EMS was explored but additional progress is needed.*

  — *A formalized dispatch system that includes training for dispatchers, physician medical direction, and pre-arrival instructions has not been implemented.*

  — *Available data is not being used to identify key community injuries/illnesses that could be addressed through illness/injury prevention programs.*

  — *Although education and training support for local EMS is included in the EMS medical director's contract, this is not occurring.*

  — *An EMS advisory committee has not been established.*

  — *Although local EMS is trying to develop a quality improvement program, they have made little progress.*

- Comments/information by case study participants related to EMS needs/issues include:

  — *"Our problem is that we need more advanced EMTs."*

Goal: Improve the Quality of Rural Health Care
Status: Outcomes Achieved/On-going Needs Exist

Indicators of Outcomes Achieved:

- Health care providers and hospital staff report that quality improvement initiatives are in place and improving quality of care.
- The hospital is converting to digital x-ray so physicians are able to receive digital images at their offices.
- Hospital staff report that they participate in skilled nursing facility QI initiatives, such as using the Nursing Home Improvement Feedback Tool (NHIFT), which is used to address four quality indicators (depression, pain, pressure ulcers, and restraints).
- Hospital staff report that quality has always been considered a "nursing issue", now it is considered a hospital-wide issue.
- Hospital staff report that they rarely used to administer aspirin at the arrival of heart patients. Now they administer it 100 percent of the time.
- Hospital staff report that by measuring quality indicators they are raising the hospital's overall awareness of the need for quality improvement.
- Hospital staff report that in the past, medical specialists often wouldn't get pre-operation orders. They have been able to improve this from 60 percent compliance to 87 percent compliance.
- Hospital staff report that discharge planning has been an on-going issue; however, in the past year, the hospital has increased compliance from 70 percent to 77 percent.

"I'd like to think it's [quality of care] always changing and improving."

— Case Study Participant

- 100 percent of health care providers surveyed as part of the case study report that their overall opinion of Franklin County Medical Center and the care provided is "Very Good" (50 percent) or "Good" (50 percent).
- When asked to report the greatest accomplishments of Franklin County Medical Center, over the past five years, health care providers surveyed as part of the case study report: "maximizing limited space and human resources to keep up with demand for services", "improved surgical services", "continued improvement in patient care and more specialty care", "physician recruitment", "new CT scanner", and "consistently high quality patient care".
- Comments/information by case study participants related to improving quality of care include:

  — *"Every time I talk to Qualis [the state's Quality Improvement Organization and a Flex Program partner], they bend over backwards to give me the information that I need."*

  — *"Ten years ago, the perception was that the hospital didn't provide high quality of care. That has changed."*

  — *"The quality of health care has changed [at the hospital]. It has improved and administration has insisted on improvement."*

  — *"The cleanliness of our hospital is top notch."*

Indicators of On-going Needs/Issues:

- Hospital staff report a need for staff, hospital-wide, to learn how to use computer software (e.g., Excel). This would improve staff's ability to track and report on quality indicators.
- Hospital staff report that electronic health record software available in the marketplace offers minimal flexibility and focuses on financial data.
- Hospital staff report a need to establish effective solutions to address discharge planning issues.
- Hospital staff report a need for increased physician involvement in quality improvement initiatives.
- Fifty percent of the health care providers surveyed as part of the case study report that Franklin County Medical Center has initiatives in place to improve the quality of care and 50 percent reported they do not know if initiatives are in place. When asked if the initiatives are improving the quality of care at Franklin County Medical Center, 40 percent reported the initiatives are improving care while 60 percent provided no response.
- Comments/information by case study participants related to quality improvement needs include:
  - *— "We've had issues with discharge planning forever. We've been able to improve but we would still like to do a better job."*
  - *— "Physicians are overloaded sometimes and do things we wish they wouldn't."*
  - *— "Our greatest barriers to quality improvement are culture change. We can only go so far if people are not willing to change."*
  - *— "We're making medication errors because the software (IT) is not functioning correctly."*

conclusions:

This case study highlights many of the local level successes and challenges of the Idaho Flex Program and Franklin County Medical Center. While it is clear that the hospital has converted to CAH status, implemented initiatives to improve hospital performance and improve quality of care, and is working to meet commuity need, it is also evident that the hospital, local EMS, and the community continue to require support in order to further advance the goals of the Flex Program and to meet community needs. In particular, those needs center around: recruiting and retaining physician and health information technology staff, obtaining financing and ultimately building a new hospital, implementing an electronic health record, continuing to develop community-hospital relations, EMS staff training, hospital and EMS quality improvement, and further engaging physicians and hospital board members in the quality improvement process.

ADDITIONAL INFORMATION:

If you have questions about the Idaho Flex Program or the Office of Rural Health and Primary Care, please contact Mary Sheridan, Director, at 208/334-0669 or via e-mail at *ruralhealth@dhw.idaho.gov*. You can find the Office of Rural Health and Primary Care on the Web at *http://www.healthandwelfare.idaho.gov/site/3459/default.aspx*

Idaho
State Office of Rural Health
& Primary Care

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